A Satyam Roychowdhury initiative

A CORRELATIONAL STUDY BETWEEN LONELINESS AND QUALITY OF LIFE AND SELF-ESTEEM AMONG OLDER ADULTS

This dissertation is submitted for the partial fulfilment for the degree of

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CERTIFICATE

This is to certify that the dissertation entitled "A Correlational Study between Loneliness and Quality of Life and Self-esteem among Older adults", submitted by Samadrita Das, a 2nd year M.Sc. student in Rehabilitation Psychology, Sister Nivedita University, is as bonafide work, which may be placed before the board of examiners for their evaluation. This is in partial fulfilment for the Degree of M.Sc. in Rehabilitation Psychology, Sister Nivedita University.

This is an original study done by the candidate and has been submitted by her before any form for any other degree of this University or any other University.

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PLAGIARISM CERTIFICATE

"I, SAMADRITA DAS, hereby declare that the research work titled "A Correlational Study between Loneliness and Quality of Life and Self-esteem among Older adults", conducted by me, has been completed with full honesty and integrity. I confirm that the work is original, and all sources of information have been appropriately acknowledged and cited. I take full responsibility for the content and findings presented in this research."

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ABSTRACT

The objective of the present study was to determine the relationship between loneliness, quality of life, and self-esteem among older adults aged 60 to 80 years. The study focused on individuals from Kolkata, and a total of 64 (n=64) participants took part in this quantitative research. UCLA (1978), OPQoL-Brief (2013) and Rosenberg Self-esteem (1965) scale were used as psychometric tools and statistical analysis (mean, SD and correlation) was done to find out the relationships among them. The results showed that there is a significant relationship between loneliness and quality of life which denotes that if loneliness increases, the quality of life tends to decrease. However, the study found no significant relationship between loneliness and self-esteem. This study highlights the interconnectedness of loneliness, quality of life, and self-esteem in older adults, offering insights fore enhancing their emotional and social well-being.

Keywords: Loneliness, Quality of Life, Self-esteem, Older Adults.

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INTRODUCTION

Old age typically refers to the later stage of life, when individuals are nearing or have surpassed the average life expectancy. People in this stage are commonly referred to as older adults, senior citizens, elders, or simply the elderly. However, what counts as "old" isn't fixed—it changes depending on cultural, historical, and social perspectives. Different fields focus on aspects of ageing in their own way—like gerontology, which looks at the biological and psychological aspects; geriatrics, which focuses on health issues in older adults; and gerontechnology, which develops tools to support ageing populations. According to the 2011 Census of India, there are around 104 million people aged 60 and above, making up 8.6% of the total population—and among them, women outnumber men. With global populations ageing quickly, projections suggest that by 2030, more than 20% of people in at least 34 countries will be over 65. This study aims to explore the relationship between loneliness, self-esteem, and quality of life in older adults between the ages of 60 and 80. Loneliness is a personal feeling that comes from not having the kind of relationships one wants—whether in number, depth, or type. It often leads to negative emotions and can affect both mental and physical health. In the UK, loneliness is commonly defined as "a subjective and unwelcome feeling which results from a mismatch in the quality and quantity of social relationships we have and those that we desire." There are two ways to look at loneliness. One focuses on how long it lasts—classifying it as either short-term (state loneliness) or long-term (trait loneliness). These two types differ not just in duration but also in their effects and causes. The second type, proposed by Weiss (1973), breaks loneliness into two categories: emotional and social. Emotional loneliness comes from the lack of close, meaningful relationships—often following loss, divorce, or distant partnerships. Social loneliness, on the other hand, is about not having a strong social network, and can result from things like moving to a new place, job loss, or being excluded from social groups. Naresh Damor and colleagues (2024) found that 40% of older adults in Gujarat, India, experienced loneliness, with key predictors including widowhood, living alone, social isolation, bereavement, depression, and disability. Lonely individuals had poorer health behaviors, such as inadequate diet, lack of exercise, poor sleep, increased smoking, and reduced social engagement. The study emphasized the need for interventions to enhance social connections and support elderly well-being.

Quality of life (QOL) is a multidimensional concept that measures a person's wellbeing. The WHO has defined QOL as: "...an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment." Four domains common to QOL in health have been defined as: physical health, mental health, social health and functional health. Dharma Raj and colleagues (2014) studied the quality of life in 166 elderly individuals in Varanasi, India. Most were literate (95.18%), with eyesight weakness as a common issue. While 61.45% had an average quality of life, 24.10% reported poor and 14.45% good quality. The study emphasized the need for old age pensions and health insurance to support elderly well-being.

According to Rosenberg (1965), self-esteem is how positively someone sees themselves overall. He explained that people with high self-esteem respect themselves and feel they are worthy. Murphy, Stosny, and Morrel (2005) also described self-esteem as a mix of how we think and feel about our self-worth. There are three main types of self-esteem. People with high

self-esteem believe in themselves, feel confident in their choices, and don't get easily upset by criticism. They don't need constant praise, but they also aren't arrogant. On the other hand, people with low self-esteem often feel like they're not good enough. They doubt themselves, avoid challenges, and are very sensitive to what others think or say. They usually depend on others to feel valued. Inflated self-esteem is different. It can lead to arrogance and the belief that one is better than others. People with this type of self-esteem might ignore their mistakes and have trouble forming close relationships because they often look down on others. Reena Rawal and Anshu (2019) examined the impact of aging on self-esteem in older adults across three aspects: performance, social, and appearance self-esteem. The results showed that nearly half had medium to high performance self-esteem, most had medium social self-esteem, and the majority had medium or low appearance self-esteem. Higher education levels were linked to greater performance self-esteem.

LITERATURE REVIEW

The correlation between loneliness, quality of life and self-esteem to assess the impact on the older adults. While numerous studies have explored the individual relationships between loneliness, quality of life and self-esteem, there is a lack of research that examines these three variables together.

Burns et al. (2020) studied the link between loneliness, health, and how often older adults use healthcare services, using data from a large national study in Ireland (TILDA). They looked at over 8,000 people aged 50 and above. Their findings showed that individuals who felt lonely tended to visit their general practitioner (GP) more often, with rates of visits being noticeably higher. However, the pattern wasn't as clear when it came to emergency department (ED) visits. After considering factors like physical health and lifestyle, they found that loneliness didn't have a strong impact on men's healthcare use. But for women, feeling lonely was linked to more ED visits during the first wave and consistently higher GP visits across both waves. The study highlights that lonely older women are more likely to use GP services, even when their health or social situation is taken into account. This suggests that GP visits might be an opportunity to identify and support those struggling with loneliness.

Haya Khaled Aman (2024) studied how loneliness is connected to depression in older adults and looked at how two things—sense of mattering and psychological adjustment—might explain this link. The research was done in geriatric homes in Cairo, Egypt. It showed that loneliness plays a big role in increasing depression levels among the elderly. Interestingly, sense of mattering explained 76% of this effect, while psychological adjustment explained 60.1%. The mediation analysis showed that both factors had a partial but meaningful impact. These findings suggest that it's not enough to just reduce loneliness—we also need to help older adults feel like they matter and support them in adjusting mentally and emotionally to their life situations in order to reduce depression.

Shrank et al. (2024) looked into how effective different interventions are in reducing loneliness among older adults living in the community, especially considering how the pandemic made loneliness worse. They reviewed a huge number of studies—5,971 in total—and narrowed it down to 60 that met their criteria (36 were randomized controlled trials and 24 were observational studies). The results showed moderate-certainty evidence that group-based treatments (SMD = -0.27) and internet training (SMD = -0.22) helped reduce loneliness. There was also some low-certainty evidence that group exercises might have a small positive effect. However, there wasn't enough strong evidence to say that other methods like one-on-one in-person visits, internet-based programs, or phone calls really work. Overall, the study suggests that group-based programs and helping older adults become more comfortable with using the internet could be effective ways to fight loneliness and should be taken seriously when planning policies and support systems for the elderly.

Pinquart and Sorensen (2001) did a meta-analysis to explore loneliness in older adults. They found that while only about 5% to 15% of older adults report feeling lonely often, the number jumps to 50% for people aged 80 and above. They also noticed a U-shaped pattern—loneliness tends to be higher in early and later old age. Interestingly, the quality of someone's social network mattered more than the number of people in it. Having meaningful connections with friends and neighbors seemed to help more than just staying in touch with family. The study also pointed out that women, people with lower socioeconomic status, lower abilities, or those

living in nursing homes were more likely to feel lonely. As people grow older, their social circles often get smaller because of things like losing a partner, less mobility, or changes in their roles. Still, loneliness is very personal—it depends a lot on what someone expects from their relationships. The researchers also mentioned that many older adults might not openly admit feeling lonely due to the stigma around it, which could mean the actual numbers are even higher.

Martín-María et al. (2021) carried out a seven-year-long study in Spain to understand how loneliness is connected to depression in adults aged 50 and above. They followed 1,190 participants and used the UCLA Loneliness Scale to track their experiences over time. They made a distinction between transient loneliness (felt during just one wave of the study) and chronic loneliness (felt throughout all three waves). About 25% of participants reported feeling lonely, and 1 in 10 showed signs of depression at the beginning. Transient loneliness was seen in 22.78% of people, while 6.72% faced chronic loneliness. Those who felt lonely for a long time had a much higher risk of developing major depression—over six times more likely (OR = 6.11), compared to a little over twice the risk for those with short-term loneliness (OR = 2.22). The strongest link between loneliness and depression showed up during the first follow-up. The study clearly shows that chronic loneliness is a serious issue and needs attention—not just medically, but also socially and politically—to prevent long-term mental health problems.

Montejo Carrasco et al. (2024) did a cross-sectional study to explore what factors predict loneliness in older adults and to figure out who is at risk and who is more protected. They collected data from a random sample of 2,060 people aged over 65 through structured telephone interviews, covering their mental and physical health, habits, quality of life, and loneliness levels. They found that poor mental health, living alone, lower quality of life, depressive symptoms, low education, and lack of social support were major predictors of loneliness. Through factor analysis, they identified three main aspects behind loneliness: subjective poor health, objective isolation, and psychological isolation. The study showed that 73.2% of people who lived alone and had poor mental health and quality of life felt lonely (risk group), while only 0.8% of those living with others and enjoying good mental health and quality of life experienced loneliness (protected group). These findings highlight that both personal feelings and actual social situations play a role in loneliness, and recognizing who is most vulnerable is key to designing better support and intervention programs.

In 2018, the AARP Foundation asked the National Academies to create a committee to look into social isolation and loneliness in adults aged 50 and older, especially focusing on how the healthcare system can help tackle this issue. The committee's findings were published in February 2020—right as COVID-19 started spreading across North America. In their review, Nancy J. Donovan and Dan Blazer (2020) shared the key takeaways from the report and discussed how they applied during the pandemic. One major point was the challenge of balancing the physical health benefits of social distancing with the need to keep people socially connected, since both are important for the overall well-being of older adults.

In 2021, Sunwoo Lee explored how getting involved in volunteer work might help older adults feel less lonely. Using data from the 2016 Health and Retirement Study in the U.S., the research focused on nearly 10,000 adults aged between 65 and 107. The study found that those who volunteered—especially in areas like youth programs or charity work—tended to feel more in control of their lives and more confident in social situations. These feelings, in turn, were linked

to lower levels of loneliness. The research also confirmed that a sense of personal control and social confidence helped explain the positive effects of volunteering. Overall, the study suggests that encouraging older adults to take part in meaningful volunteer roles could be a helpful way to support their emotional and social well-being.

Berg-Weger and Morley (2020) talked about how loneliness and social isolation are becoming more common among older adults. A big part of this is because many live alone and are less involved in social or religious activities. Former U.S. Surgeon General Vivek Murthy even called loneliness a global epidemic. Research shows that about a third—or even more—of older adults feel lonely, and around 5% say they feel this way all the time. In the U.S., the numbers vary a lot, with estimates ranging from 17% to 57%, especially among those dealing with physical or mental health issues like heart disease, depression, anxiety, or dementia. The impact of loneliness goes beyond just feeling sad—it can seriously harm both physical and emotional health. Over time (four years or more), it can lead to higher blood pressure, weight gain, depression, increased use of alcohol or drugs, and more isolation. It also affects sleep, memory, physical activity, and even raises the risk of stroke and heart disease.

Fakoya, McCorry, and Donnelly (2020) conducted a comprehensive review of interventions aimed at reducing loneliness and social isolation among older adults. They found that about half of individuals aged 60 and above are at risk of experiencing social isolation, with one-third reporting feelings of loneliness later in life. The review involved analyzing 33 published studies from databases such as CINAHL, Embase, and Medline. One key takeaway was that there were inconsistencies in how interventions were categorized and labeled, with many studies using similar terms without offering precise definitions. Most interventions were grouped based on their method of delivery (group or individual), goals, and type. The authors concluded that due to the individualized nature of loneliness, a standardized intervention approach is challenging. Therefore, it's crucial to tailor interventions to the specific needs of different groups and the severity of loneliness. They also recommended that future research should focus on identifying which interventions work best for various individuals in diverse situations.

Pearl A. Dykstra (2009) explored the social dimensions of quality of life, particularly focusing on loneliness in older adults, and challenged three common beliefs about it. First, loneliness is not an issue for all older adults; it tends to be more common among the very elderly rather than the general older population. Second, living in individualistic societies doesn't automatically mean people are lonelier. In fact, older adults in northern Europe report feeling less lonely than those in southern Europe, where family ties are stronger. Although central and eastern Europe have higher rates of loneliness, the data is somewhat limited. Finally, loneliness hasn't increased over time—in fact, there's been a slight decline in loneliness. The review also pointed out the persistence of ageist attitudes and stressed the importance of considering individual perspectives and cultural norms when studying loneliness.

Aartsen and Jylhä (2011) conducted a long-term study on the development of loneliness in older adults, using data from the TamELSA study in Finland. They tracked 469 individuals aged 60 to 86 who weren't lonely at the start of the study over a 28-year period (1979–2006). The results showed that about one-third (178 participants) became lonely over time. Key factors leading to loneliness included losing a partner, decreased social activities, physical disabilities, and feelings of low mood, uselessness, and nervousness—rather than the baseline characteristics of participants. Although women had higher rates of loneliness, this was largely

due to their greater exposure to risk factors like widowhood. The findings align with the cognitive approach to loneliness, which suggests that loneliness stems from a gap between desired and actual social and personal resources.

Ann Bowling (2013) stressed the importance of accurately measuring quality of life in older adults, a key global focus. In this study, she introduced a shortened version of the OPQOL-35, called the OPQOL-brief, which was developed by gathering input from older adults on the most important aspects of quality of life. The shortened version was then tested for reliability and validity using a population sample. To compare the results, a national survey of individuals aged 65 and older was conducted, alongside comparisons with other established quality-of-life measures like WHOQOL-QOL and CASP19. The findings confirmed that the OPQOL-brief is a valid and reliable tool for assessing quality of life in older adults. Bowling concluded that this shorter form provides a useful, rigorously tested option for interventions requiring a concise quality-of-life measure. The study also highlights the importance of involving older adults in the design of such tools, in line with international research and policy goals.

Halvorsud and Kalfoss (2007) conducted a narrative review to identify suitable quality of life (QoL) measurement tools for older adults across various settings. They analyzed 47 studies published between 1994 and 2006, focusing on the conceptual frameworks, definitions of QoL, types of measurements, and psychometric properties. The review identified 40 different QoL instruments, most of which assessed functional status and symptoms. The SF-36 showed the strongest psychometric evidence, though many studies lacked comprehensive validation. A significant finding was that 87% of the studies didn't use a conceptual framework, and 55% overlooked key methodological issues related to older adults. The study stressed the importance of establishing quality control standards for consistent reporting of measurement properties and called for the development of standardized, multidimensional, and person-centered QoL models through international collaboration in gerontology research.

Butler and Ciarrochi (2007) explored the impact of psychological acceptance (PA) on quality of life (QoL) in older adults, particularly in the context of age-related challenges such as decreased productivity. They studied 187 elderly individuals (aged 65–96) from home nursing services, retirement villages, and community groups, using a PA scale and the Comprehensive Quality of Life Scale (COMQol). The results indicated that higher levels of PA were associated with better QoL, especially in areas like health, safety, community engagement, and emotional well-being. Moreover, those with high PA were less likely to experience negative psychological effects from a decline in productivity. The study suggests that promoting PA through interventions could help older adults manage the stressors of aging, improve mental health, and maintain a high subjective quality of life despite physical and social changes.

Mohamed, Mourad, and Abd El-Fatah (2020) examined the quality of life (QoL) among elderly residents in geriatric homes in Beni-Suef, Egypt. The study involved 20 elderly individuals from two facilities and used a socio-demographic questionnaire, the Facts on Aging Quiz, and the Older People's Quality of Life Questionnaire. The findings revealed that 70% of participants reported a lower QoL, and 85% had insufficient knowledge about aging-related changes. A negative correlation was found between sex and income source with overall QoL, while higher education levels and frequent visits from others were linked to better QoL. The study suggests implementing a psycho-educational program to enhance elderly well-being and recommends training nurses to better manage the psychological impacts of aging.

Liu et al. (2023) investigated how high altitude affects quality of life (QoL) in older adults by comparing those living in high-altitude (Xining) and low-altitude (Guangzhou) areas. Using the WHOQOL-BREF scale, they assessed QoL across physical, psychological, and social domains in 644 older adults (39.1% male). After adjusting for various factors, the results showed that residents in high-altitude areas had better physical and social QoL but lower psychological QoL compared to those in low-altitude areas. Among high-altitude residents, factors such as smoking were associated with better social QoL, good financial status with higher physical QoL, and better health with improved physical and psychological QoL. However, severe depressive symptoms were linked to lower QoL. The study suggests that interventions addressing mental health, financial security, and overall well-being could improve the QoL of older adults living in high-altitude regions.

Imanishi, Tomohisa, and Higaki (2015) conducted a survey of 200 elderly individuals receiving in-home care services to assess their quality of life (QOL) using the PGC Morale Scale. Multivariate analysis identified several factors influencing QOL, with the most significant being the reason for choosing in-home care and family structure. The average PGC-MS score was 9.09 ± 2.6. Those who chose in-home care after hospital treatment reported higher QOL scores compared to those who chose it during hospitalization. Regarding family structure, three-generation households had the highest QOL, followed by individuals living alone, couples, and two-generation families. The study emphasizes the importance of considering both personal choices and social factors in the design of in-home care services to improve elderly well-being.

Alaazi et al. (2020) investigated the quality of life (QoL) of older adults in Accra, Ghana, comparing residents of slum and non-slum areas. Using the WHOQoL-BREF tool, they assessed QoL across four domains—physical, psychological, social, and environmental—through a cross-sectional survey of 603 participants. The results showed no significant differences between slum and non-slum residents in physical and psychological QoL. However, slum dwellers reported significantly higher social QoL, while non-slum residents had better environmental QoL. These differences were likely influenced by stronger social support networks in slums and better housing and neighborhood conditions in non-slum areas. The study challenges the common view that slums are universally detrimental to health, suggesting that certain aspects of slum life, like strong social connections, may actually enhance older adults' well-being.

Penton et al. (2022) explored how older adults define quality of life (QoL) and assessed the content validity of four QoL measures: EQ-5D-5L, SF-12v2, WEMWBS, and ONS-4. Through 20 cognitive interviews with individuals aged 75 and older, the study found that QoL was primarily understood in terms of health, the ability to perform daily tasks, social connections, and emotional well-being. Participants often adjusted their health assessments based on expectations of aging or comparisons with others. They preferred the function-based EQ-5D-5L over the more subjective WEMWBS and ONS-4, raising concerns about the relevance of negatively worded mental health items. To enhance comprehensiveness, they recommended adding domains like social contact, coping, security, dignity, and control. The study offers valuable insights for refining existing QoL measures or developing new ones that more accurately reflect the experiences of older adults.

Borglin, Edberg, and Hallberg (2004) investigated how the oldest old (80+) perceive quality of life (QoL) through 11 in-depth interviews with older adults living at home. Using interpretative hermeneutic phenomenological analysis, the study found that QoL was closely tied to maintaining a sense of self and finding meaning in life. Participants placed value on having a coherent life story and based their QoL assessments on areas that were personally significant to them. In addition to common QoL measures, factors such as the meaning of home, life perspectives, thoughts on death, and storytelling emerged as key elements. The study suggests that QoL assessments should expand beyond health measures to incorporate existential and emotional aspects. For nursing care, the findings highlight the importance of life review, addressing existential concerns, supporting family involvement, and helping older adults remain in their homes to improve their QoL.

Iždonaitė Medžiūnienė and Preikšaitienė (2024) conducted a study examining the overall quality of life (QoL) in older adults, considering various aspects of life rather than focusing solely on health conditions or diseases. They used a mixed-methods approach, which combined surveys and interviews, with participants from a university for older adults and the "Healthy Aging Program." The results indicated that emotional and physical health were rated the lowest, while social health received the highest ratings. Despite concerns about their quality of life, participants were hesitant to make significant changes to their lifestyle, such as increasing water intake, exercising, or planning meals. There was also a reluctance to take steps to improve psychosocial well-being. In general, the QoL scores were below average, pointing to a lack of preparedness or knowledge in adopting healthier habits, even though the older adults recognized the need for improvement.

In a 2000 study, McAuley and his team explored how older adults' self-esteem is influenced by different forms of physical activity over time. They worked with 174 participants who joined either a walking or a stretching and toning program. The study spanned a full year—six months of guided exercise followed by six months without intervention—to observe any changes in self-perceptions related to physical self-worth. They found that participants experienced a boost in self-esteem during the exercise phase, but this increase began to decline after the program ended. Factors like how often someone exercised, improvements in physical fitness, body changes, and especially their confidence in their own abilities (self-efficacy) all contributed to more positive views about strength, appearance, and physical health. Interestingly, the findings suggested that these boosts in how people felt about their physical selves were largely shaped by the psychological benefits of feeling more capable and fit.

Yuji Ogihara's (2019) study explored how self-esteem varies across different ages in Japan, especially from middle age into older adulthood. While previous research in Western settings—particularly among European Americans—has shown that self-esteem tends to rise into middle age and then drops significantly after the 50s or 60s, it wasn't clear if the same trend held true in Japan. Using a large and diverse Japanese sample, Ogihara found that although self-esteem did increase with age up to middle adulthood (just like in Western findings), it did not show a sharp drop-off in later years. One possible reason behind this difference may lie in cultural norms: East Asian societies often place more value on humility and modesty, which might buffer against the dramatic shifts in self-view that are more commonly observed in Western cultures.

Turhan Toros and his team (2023) explored how regular exercise influences life satisfaction, self-esteem, and self-efficacy in men aged 65 and above. The study, which included 215 participants, found that those who maintained a regular exercise routine scored noticeably higher across all three areas compared to those who didn't exercise. Interestingly, the positive effects became more pronounced with age and longer exercise history. Among regular exercisers, there was a strong link between feeling satisfied with life, having confidence in oneself, and believing in one's abilities. These relationships were much weaker in those who didn't work out regularly. Overall, the findings underline how consistent physical activity can play a big role in improving the overall well-being of older men.

Ulrich Orth, Kali H. Trzesniewski, and Richard W. Robins (2010) explored how self-esteem changes across adulthood using data from the Americans' Changing Lives study, which followed over 3,600 people for 16 years. Their findings showed that self-esteem tends to rise through young and middle adulthood, hits its peak around age 60, and then gradually declines in older age. Interestingly, they didn't find any major generational differences. Women started off with lower self-esteem compared to men, but the gap closed later in life. Similarly, while self-esteem levels were similar between Black and White participants earlier on, Black individuals experienced a sharper drop in their later years. Education played a role—those with higher education generally had better self-esteem—but the overall pattern over time was the same. Much of the late-life decline was tied to shifts in financial stability and health.

Lucie Baker and Eyal Gringart (2009) looked into how body image relates to self-esteem in older adults—an area that's often overlooked, even though the ageing population is growing fast, especially in Australia. They worked with 148 older adults aged 65 to 85, all living independently in Perth, who filled out the Rosenberg Self-Esteem Scale and the Multidimensional Body-Self Relations Questionnaire. The results pushed back against the common belief that body image doesn't matter much in later life. It clearly does, though it plays out differently depending on age and gender. Women seemed to develop coping strategies to handle the physical changes that come with ageing, while men were more likely to struggle—especially when it came to how their bodies functioned. Overall, the study emphasized how important it is to pay attention to body image in older age, since it can play a big role in self-worth, mental health, and quality of life.

Sonja Šare and her team (2021) explored how the kind of care and social environment older adults live in can impact their mental health. They studied people aged 65 and above in Zadar County, Croatia, looking at levels of depression, anxiety, and self-esteem through standardized mental health tools. What they found was pretty telling—those living in nursing homes had noticeably lower self-esteem and higher depression and anxiety compared to those staying in their own homes. There was a clear pattern: as depression went up, self-esteem dropped, and depression and anxiety were closely connected. Older adults who were widowed also tended to have lower self-esteem, and depression became more common with age. Living in an institution was almost significantly tied to higher anxiety, and gender made a difference too. The study really highlighted how important it is to offer compassionate, person-centered care—whether someone's in a facility or living independently—and the need for stronger mental health support for the elderly in both settings.

Ineke Demeyer, Nuria Romero, and Rudi De Raedt (2018) looked into how the gap between how older adults actually see themselves and how they wish to see themselves affects their

emotional well-being. They worked with 49 older participants, using two customized Go/No-Go Association Tasks (GNAT) to measure implicit actual and ideal self-esteem—basically, self-esteem we may not always be fully aware of. The tasks turned out to be pretty reliable. What they found was that when someone's ideal self-esteem is high, but their actual self-esteem is low, sadness tends to creep in more. On top of that, lower actual self-esteem was tied to higher anxiety. The study really points out how valuable it is to have self-esteem tools made specifically for older adults, especially if we want to better understand their emotional health and offer more effective support.

Le Zhao, Xing Zhang, and Guangming Ran (2017) explored how self-esteem and coping styles are connected to loneliness in older adults. They studied 312 people aged 60 to 88 from the Beibei District in Chongqing, China, using self-report questionnaires. The results showed a strong link between self-esteem, coping strategies, and loneliness. What stood out was that people with higher self-esteem tended to use more positive ways of coping, which helped ease their feelings of loneliness. In other words, having a stronger sense of self seemed to encourage healthier responses to challenges, which then made people feel less alone. This study sheds light on how building self-esteem can be a helpful path to reducing loneliness later in life.

Beata Mirucka, Urszula Bielecka, and Monika Kisielewska (2016) looked into how older adults' subjective age—how old they feel—relates to their self-esteem and life satisfaction. They worked with 194 seniors and measured positivity, self-esteem, and life satisfaction. Most participants felt younger than their actual age, and that feeling turned out to be important. Their analysis showed that feeling younger (rather than actually being younger) was a better predictor of how satisfied and confident people felt about their lives. Interestingly, this effect held up even when health status was considered, while chronological age didn't show much impact. The study highlights that how older adults perceive their age plays a bigger role in well-being than the number on their birth certificate.

Jing Chen and colleagues (2018) looked into how older adults think and feel about aging, both on the surface and beneath it, and how those views relate to their self-esteem. They studied 70 people between the ages of 60 and 91, using both self-report tools and an Implicit Association Test to capture both conscious and unconscious attitudes. What they found was a bit of a disconnect—while most participants openly reported positive views about aging and had high self-esteem, their unconscious responses suggested more negative beliefs about aging and lower self-worth. Interestingly, the way people consciously viewed themselves and aging (explicit self-esteem and attitudes) didn't necessarily align with their unconscious (implicit) patterns. For example, someone might report feeling good about themselves and growing older, while still having subtle, negative associations below the surface. The study highlights how layered and complex self-esteem can be in older adulthood, especially when it comes to internalized views on aging.

METHODOLOGY

Objectives:

To determine the relationship between loneliness, quality of life and self-esteem.

Hypothesis:

- There is no significant relationship between loneliness and quality of life.
- There is a significant relationship between loneliness and quality of life.
- There is no significant relationship between loneliness and self-esteem.
- There is a significant relationship between loneliness and self-esteem.

Variables:

In this research, three variables were measured. There were Loneliness, Quality of life and Self-esteem.

- **Loneliness -** Loneliness is often defined as the feeling that one's desired quantity or quality of social connections is unfulfilled (Peplau and Perlman, 1982; Hawkley and Cacioppo, 2010). Loneliness is universal and may have evolved in our species as a signaling mechanism to change behavior and avoid dangerous isolation (Cacioppo and Patrick, 2008).
- **Quality of life -** In 1947, the World Health Organization (WHO) defined QoL as a "state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity".
- **Self-esteem -** According to self-esteem expert Morris Rosenberg, self-esteem is quite simply one's attitude toward oneself (1965). He described it as a "favourable or unfavourable attitude toward the self". Self-esteem is based on evaluating the self, and rating one's behaviors and qualities as positive or negative, which results in defining the self as worthy or non-worthy (Ellis, 1994).

Tools:

- **UCLA Loneliness Scale –** The University of California, Los Angeles Loneliness Scale (UCLA Loneliness Scale) was developed by Russell, Peplau, and Ferguson in 1978. It was the first standardized tool that measured subjective loneliness and social isolation. This scale had 20 items and was designed as unidimensional. It had no reverse-scored items, and the responses were scored as "3 for often feeling, 2 for feeling sometimes, 1 for feeling rarely, and 0 for feeling never." There were two revised versions of this scale: the Revised UCLA Loneliness Scale (R-UCLA 1980) and the UCLA Loneliness Scale (Version 3) (1996). The UCLA Loneliness Scale was a valid and reliable measure with high internal consistency (Cronbach's alpha = 0.94) and test-retest reliability (r = 0.73).
- **OPQOL-Brief –** The Older People's Quality of Life (OPQOL-Brief) scale is a short version of OPQOL-35. It was developed by Ann Bowling in 2013. This scale is widely used to assess the quality of life in older adults. It consists of 13 items that cover aspects of well-being including health, social relationships, independence, financial security, environment, and overall life satisfaction. For scoring, each item is coded as a reverse item so that higher scores represent a higher quality of life. Each item is rated on a 5-point Likert scale from Strongly Disagree (1) to Strongly Agree (5). All the scores are

added to obtain the quality of life. Cronbach's alpha > 0.80 has proven the good reliability of the scale, representing internal consistency. Construct validity is evidenced by the strong correlation of this variable with self-rated quality of life and other related dimensions of well-being.

- **Rosenberg's Self-esteem Scale** – Morris Rosenberg devised the Rosenberg Self-Esteem Scale (RSES) to measure global self-esteem in 1965, which is one's overall sense of self-worth and self-acceptance. It is one of the most commonly used self-esteem assessment tools within psychology and social research. The scale includes 10 items, comprising five positively worded statements and five negatively worded statements. Items are rated on a four-point Likert scale from strongly agree (3) to strongly disagree (0), with a higher score indicating a greater degree of self-esteem. The RSES has shown to be a highly reliable resource, exhibiting Cronbach's alpha between 0.77 and 0.88 to ensure internal consistency. It has strong construct validity as it correlates highly with depression, self-confidence, and psychological well-being measures. The scale has predictive validity as self-esteem scores have been associated with mental health, life satisfaction, and social functioning.

Sample:

A total of 64 participants, aged between 60 and 80 years, are presented as a sample in this study.

Inclusion criteria:

- ❑ Individuals who are between the age group of 60 and 80 years are selected.
- ❑ Both males and females are included.
- ❑ Individuals capable of reading and writing in English are also included.

Exclusion criteria:

- ❑ Individuals diagnosed with physical disorders are excluded.
- ❑ Individuals with mental health issues and psychological disorders are also excluded.
- ❑ Individuals who have not passed the higher secondary examination are excluded.

Sampling technique:

Purposive sampling technique is used to collect data in this research.

Procedure:

Participants who were older adults aged between 60 and 80 years were selected for this research. Sixty-four individuals were selected for this research. The data collection was done in offline mode by providing them with questionnaires. First, they had to read the consent form and sign it. After that, they had to fill out sociodemographic details and give responses to the scales to measure their loneliness, quality of life, and self-esteem. The responses in the scales were scored accordingly. Then, the scores were written in an Excel sheet for prior calculation through descriptive statistics in SPSS. The Rho (Spearman) calculation was done in SPSS to determine the relationship between loneliness, quality of life, and self-esteem. Lastly, the results were presented in a table, discussed, and the conclusion was drawn based on this.

Statistics:

Mean, SD and Rho (Spearman) had been followed in this research.

RESULT

Table 1

Table 1 is showing mean values for the three variables as – loneliness, quality of life and self-esteem.

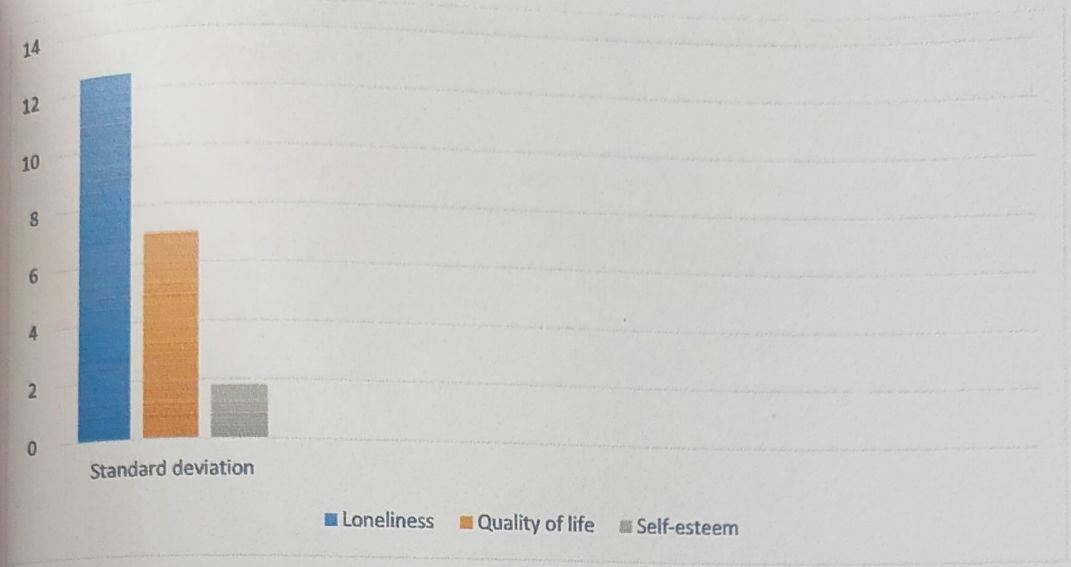
Loneliness	Quality of life	Self-esteem
13.20	54.19	15.38

The scores indicate a low level of loneliness, high quality of life and average self-esteem among the participants.

Table 2

Table 2 is showing the standard deviation values for the three variables as loneliness, quality of life and self-esteem.

Loneliness	Quality of life	Self-esteem
12.541	7.019	1.795

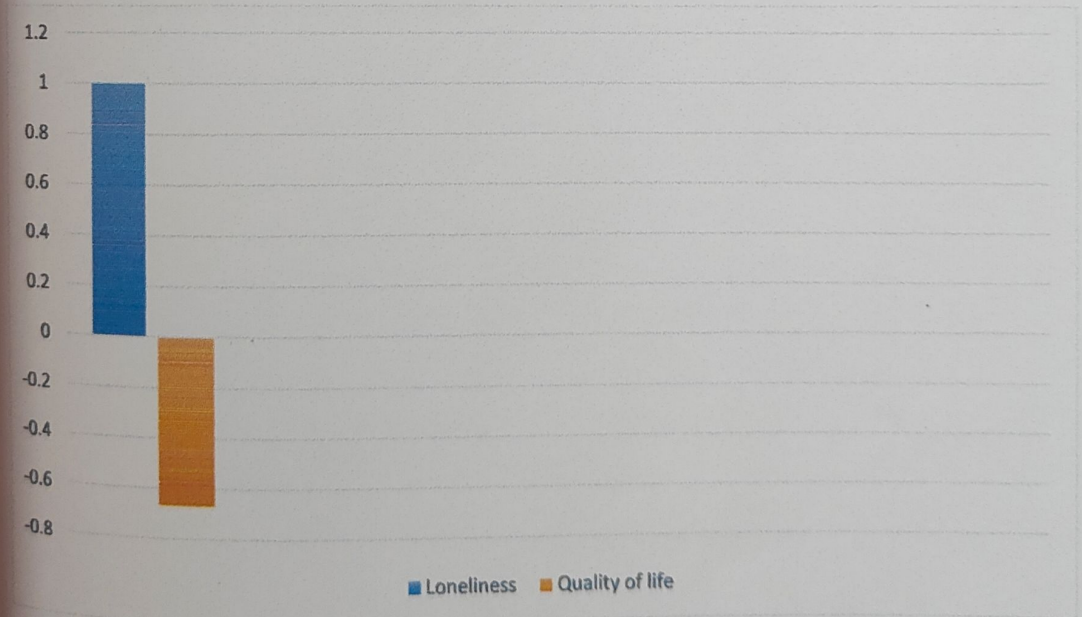


The standard deviation for loneliness is the highest, indicating greater variability in responses, while the standard deviation for self-esteem is the lowest, indicating more consistency. Higher standard deviation values suggest that the data are more inconsistently distributed across the sample, whereas lower standard deviation values indicate more consistent distribution.

Table 3

Table 3 is showing the correlation values of loneliness and quality of life.

Loneliness	Quality of life
1.000	-.668**



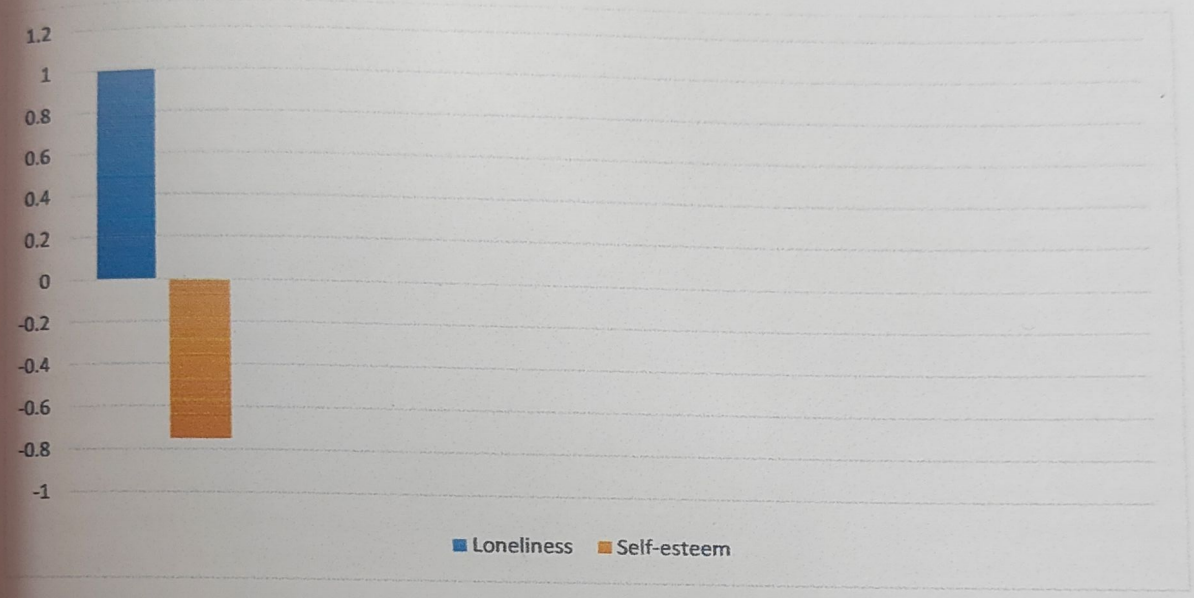
** Significant at 0.01 level (2-tailed).

The correlation between loneliness and quality of life is statistically significant at 0.01 level. Therefore, the null hypothesis is rejected.

Table 4

Table 4 is showing the correlation values of loneliness and self-esteem.

Loneliness	Self-esteem
1.000	-0.75



The correlation between loneliness and self-esteem is not statistically significant at 0.01 level. Therefore, the null hypothesis is accepted.

DISCUSSION

The objective of the present research was to determine the relationship between loneliness, quality of life, and self-esteem in older adults. In this research, loneliness was measured using the UCLA Loneliness Scale (University of California, Los Angeles Loneliness Scale). According to Table 1, the mean value of loneliness was 13.20, indicating a low level of loneliness. This may indicate that the individual rarely feels socially isolated, has access to supportive relationships and is generally satisfied with their social interactions. Items like "I am unhappy doing so many things alone" and "I feel left out" suggest that they are comfortable with solitude and rarely feel left out in social situations, further supporting the low level of perceived loneliness among the participants. This finding is not consistent with previous studies. A study conducted by Haya Khaled Aman (2024) reported a mean score of 45.6, indicating a high sense of loneliness. This differs from the present study because the scale used for measuring loneliness (UCLA Version-3) was different from the scale used here. Additionally, the sample size of the previous study (200) was larger than that of the present study. Finally, the data from the previous study were collected from 24 geriatric homes in Cairo, Egypt. The variable quality of life was assessed using the OPQOL-Brief (Older People's Quality of Life) scale. In the present study, the mean score was 54.19, indicating a high level of quality of life among older adults. This relatively high score implies that most participants were satisfied with important areas of life such as health, safety, social relationships, independence, and emotional well-being. Items such as "I enjoy my life overall" and "I am healthy enough to get out and about" suggest that they not only find joy and meaning in their daily lives but also feel physically capable of staying active and socially engaged. This result aligns closely with the findings of Bužgová et al. (2022), who examined the psychometric properties of the Czech version of the OPQOL-Brief and reported a mean score of 54.49. The similarity in findings supports the reliability and consistency of the scale across different populations. Self-esteem, the third variable, was measured using the Rosenberg Self-Esteem Scale. The mean score in the present study was 15.38, indicating an average level of self-esteem among older adults. This score reflects those participants likely gave mixed responses—agreeing with some positive statements such as "I feel that I have a number of good qualities" or "I feel that I am a person of worth", while also possibly expressing some doubts or disagreements on items like "I feel I do not have much to be proud of" (reverse scored). It suggests a balanced or average self-view, for both strength and vulnerability in their self-perception. This finding contrasts with a previous study conducted by Jafari, Khatony, and Malek (2015), which reported a mean score of 35.63, reflecting a high level of self-esteem. The participants in their study were selected from counseling centers in Kermanshah, Iran, which may have influenced the higher self-esteem scores due to access to psychological support and interventions. In contrast, the present study involved a general population sample, which may account for the comparatively lower self-esteem levels observed. Additionally, differences in cultural, social, and environmental contexts may have contributed to the variation in results.

According to Table 2, the standard deviations for the three variables—loneliness, quality of life, and self-esteem—were 12.541, 7.019, and 1.795, respectively. Among these, the standard deviation scores for loneliness and quality of life were notably higher than that of self-esteem, indicating a greater variability in responses across the sample. Higher standard deviation values suggest more inconsistent distribution of scores, while lower values, such as that for self-esteem, reflect more consistency within the sample. The findings of the present study are

somewhat inconsistent with previous research. For instance, a study by Haya Khaled Aman (2024) reported a standard deviation of 15.7 for loneliness, which, despite being higher than the present study's value, similarly indicated a wide variability in loneliness scores. Regarding quality of life, the current study reported a standard deviation of 7.019, which contrasts with the findings of Butler and Ciarrochi (2007), who reported a standard deviation of 0.43 for objective quality of life and 3.45 for subjective quality of life. These lower values suggest a more consistent distribution of scores in their sample compared to the present study. Such discrepancies may be attributed to differences in measurement tools and sample characteristics. Butler and Ciarrochi (2007) utilized the COMQoL-A5 (Comprehensive Quality of Life Scale), which assesses seven domains: material well-being, health, productivity, intimacy, safety, place in community, and emotional well-being. Additionally, their sample consisted of 187 older adults aged 65–96, drawn from home nursing services, retirement villages, and various community groups. In contrast, the present study employed the OPQOL-Brief and involved a different demographic, which may explain the variation in standard deviation scores.

Table 3 presented the correlation between loneliness and quality of life. The correlation coefficient for loneliness was 1.000, while the correlation between loneliness and quality of life was found to be –0.668, indicating a strong negative relationship. This correlation was statistically significant at the 0.01 level ($\alpha = 0.01$), leading to the rejection of the null hypothesis and acceptance of the alternative hypothesis, which posited a significant negative correlation between the two variables. These findings are consistent with a study conducted by Hülya Arslantaş (2015), which explored factors influencing loneliness among older adults and its relationship with quality of life. The earlier study concluded that loneliness negatively impacts quality of life in old age, with factors such as chronic health issues and lack of hobbies identified as significant predictors of loneliness. While the present study did not examine specific predictors, the core finding of a negative relationship between loneliness and quality of life remains aligned. There were, however, several methodological and contextual differences between the two studies. Arslantaş (2015) utilized a larger sample ($n = 174$) and employed a multi-stage sampling method, whereas the present study involved a smaller sample from the general population in Kolkata. Additionally, different measurement tools were used: the previous study employed the Quality of Life (QoL) Short Form (SF-36) Scale, while the current study used the OPQOL-Brief. Moreover, the significance level in the prior study was set at 0.05, compared to 0.01 in the present study. Despite these differences, both studies used Spearman's correlation analysis to examine the relationship between loneliness and quality of life, supporting the comparability of the findings.

Table 4 displays the correlation between loneliness and self-esteem. The correlation coefficient for loneliness was 1.000, while the correlation between loneliness and self-esteem was found to be –0.75, indicating a strong negative relationship. However, this correlation was not statistically significant at the 0.01 level, leading to the acceptance of the null hypothesis and the rejection of the alternative hypothesis. Despite the lack of statistical significance, the result is consistent with previous research. A study by Małgorzata Szcześniak (2020) examined the role of self-esteem in the relationship between loneliness and life satisfaction in late adulthood. While the previous study explored a broader framework involving life satisfaction, it also reported a negative correlation between loneliness and self-esteem, similar to the finding in the present study. There were some methodological differences between the two studies. Szcześniak's research involved a sample of 179 older adults aged 60–89 and used a

convenience sampling method, whereas the present study used purposive sampling and included participants aged 60–80. Both studies used the Rosenberg Self-Esteem Scale to assess self-esteem. However, different tools were used to measure loneliness: the previous study employed the De Jong Gierveld Loneliness Scale, while the present study used the UCLA Loneliness Scale. Additionally, the previous data was collected in Poland before the COVID-19 pandemic, whereas the current study was conducted in Kolkata after the pandemic. Despite these contextual and methodological differences, the similarity in correlation coefficients $r = -0.74$ in the previous study and $r = -0.75$ in the present study suggests a consistent negative relationship between loneliness and self-esteem in older adults.

CONCLUSION

It can be concluded that the findings are:

- There is no significant relationship between loneliness and quality of life, i.e., the null hypothesis is rejected.
- There is no significant relationship between loneliness self-esteem, i.e., the null hypothesis is accepted.

IMPLICATIONS

This study gives a better understanding of how loneliness, quality of life, and self-esteem are related among older adults. The findings highlight the importance of addressing emotional and social well-being in this age group. This can be useful for caregivers, mental health professionals, and policy makers to think about ways to improve the overall well-being of older people. Encouraging more social interaction, support, and positive self-image can help reduce loneliness and improve life satisfaction. The study also provides a base for future research and can be helpful in planning community-based programs for the elderly.

LIMITATIONS

This research included only 64 older adults, so the results might not reflect the wider population. Since the participants were from just one city—Kolkata—the outcomes could be different in other places. Collecting data was also slightly challenging because older adults sometimes got tired or impatient while filling out the forms. Although they all had at least a higher secondary education and were physically and mentally healthy, it still took time to explain and complete the questionnaires. Also, GHQ (General Health Questionnaire) was not administered separately, so the mental health status was taken based on self-report and observation. In the future, using a bigger and more mixed group could help make the findings stronger and more general.

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APPENDIX

I am Samadrita Das, a final-year MSC student in Applied Psychology at Sister Nivedita University, Kolkata. This is my project dissertation on elderly people, referred to here as older adults. You will be asked to respond to some questionnaires, which will take some time. There are no right or wrong answers. The data will be used solely for research purposes and will be kept confidential. Your voluntary participation will greatly contribute to the success of this research. Thank you for your participation and cooperation.

To signify your approval to participate in this study, please give your name, signature and contact details below:

Name:

Signature:

Contact details:

SOCIODEMOGRAPHIC DATA:

Name (Initials) –

Age –

Sex –

Locality – Urban/Suburban/Rural

Educational Qualification –

Language known –

Occupation –

Physical Disability (if any) –

Psychiatric History (if any) –

UCLA

Instructions: Indicate how often each of the statements below is descriptive of you. O indicates "I often feel this way", S indicates "I sometimes feel this way", R indicates "I rarely feel this way", N indicates "I never feel this way".

1. I am unhappy doing so many things alone. O S R N
2. I have nobody to talk to. O S R N
3. I cannot tolerate being so alone. O S R N
4. I lack companionship. O S R N
5. I feel as if nobody really understands me. O S R N
6. I find myself waiting for people to call or write. O S R N
7. There is no one I can turn to. O S R N
8. I am no longer close to anyone. O S R N
9. My interests and ideas are not shared by those around me. O S R N
10. I feel left out. O S R N
11. I feel completely alone. O S R N

12. I am unable to reach out and communicate with those around me. O S R N
13. My social relationships are superficial. O S R N
14. I feel starved for company. O S R N
15. No one really knows me well. O S R N
16. I feel isolated from others. O S R N
17. I am unhappy being so withdrawn. O S R N
18. It is difficult for me to make friends. O S R N
19. I feel shut out and excluded by others. O S R N
20. People are around me but not with me. O S R N

OPQoL-Brief

We would like to ask you about your quality of life:

Single item - global QoL:

1) Thinking about both the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole? Your quality of life as a whole is: Very good/ Good/ Alright/Bad/ Very bad

Instruction: Please tick any one from "Strongly agree" to "Strongly disagree". Please select the response that best describes you/your views. There are no right or wrong answers.

1. I enjoy my life overall. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
2. I look forward to things. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
3. I am healthy enough to get out and about. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
4. My family, friends or neighbours would help me if needed. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
5. I have social or leisure activities/ hobbies that I enjoy doing. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
6. I try to stay involved with things. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
7. I am healthy enough to have my independence. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
8. I can please myself what I do. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
9. I feel safe where I live. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
10. I get pleasure from my home. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
11. I take life as it comes and make the best of things. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
12. I feel lucky compared to most people. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree
13. I have enough money to pay for household bills. Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

Rosenberg Self-esteem Scale

Instructions: Below is a list of statements dealing with your general feelings about yourself. There are four possible answers for each of the 10 questions, from "strongly agree" to "strongly disagree. Choose the box to indicate how strongly you agree or disagree with each statement.

	Strongly agree	Agree	Disagree	Strongly disagree
On the whole, I am satisfied with myself.	3	2	1	0
At times, I think I am no good at all.	3	2	1	0
I feel that I have a number of good qualities.	3	2	1	0
I am able to do things as well as most other people.	3	2	1	0
I feel I do not have much to be proud of.	3	2	1	0
I certainly feel useless at times.	3	2	1	0
I feel that I'm a person of worth, at least on an equal plane with others.	3	2	1	0
I wish I could have more respect for myself.	3	2	1	0
All in all, I am inclined to feel that I am a failure.	3	2	1	0
I take a positive attitude toward myself.	3	2	1	0